

DIRECT WORK WITH SEXUALLY EXPLOITED OR AT RISK CHILDREN AND YOUNG PEOPLE

A RAPID EVIDENCE ASSESSMENT

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INTRODUCTION

This review is intended to provide Barnardo's with an overview of what 'direct work' with young people entails in the context of CSE. Part one explores the nature, types and contexts of direct work and gives an overview of the range of risks and vulnerabilities that direct work typically addresses. Part two focuses on the journey of direct work with young people in greater detail and outlines six core elements of direct interventions:

1. Engagement and relationship building
2. Support and stability
3. Providing advocacy
4. Reducing risks and building resilience
5. Addressing underlying issues
6. Enabling growth and moving on

The discussion of each component is informed by what we know from research evidence to work in direct interventions with young people. We also give some practice examples to illustrate effective models of direct work.

Part three provides a brief summary of the key features that underpin effective direct work with young people.

A NOTE ON THE EVIDENCE

Although there are a number of different interventions aimed at addressing the needs of young people affected by CSE in the UK, not many have been rigorously evaluated.

Barnardo's 'Reducing the Risk' is the only large scale evaluation that has attempted to quantitatively measure outcomes for young people receiving specialist CSE services in the UK (Scott and Skidmore 2006).

While there is comparatively little evidence specifically relating to direct work addressing CSE, there is very relevant evidence on what works for young people with similar or related issues in their lives. This review therefore draws on evidence relating to what works in responding to child sexual abuse, child and adolescent mental health problems and youth offending and identifies some transferable learning from the literature on engaging children and young people, strengths-based approaches and promoting resilience.

OVERVIEW OF FINDINGS

WHAT UNDERPINS GOOD DIRECT WORK?

FEATURES OF EFFECTIVE DIRECT WORK WITH CSE-AFFECTED YOUNG PEOPLE

- **Relationships** are key to engagement - **engagement** and **trust**-building are the foundation of direct work. Involving young people in setting the agenda and pace of direct work can facilitate engagement and 'buy in'.
- Interventions should be **centred around the child**. Consulting young people can enhance risk assessments. It can help to develop appropriate risk reduction strategies and care plans that are tailored to the needs of the child.
- **CSE is complex**. Direct work should be **holistic** and should address the **multiple vulnerabilities** many CSE-affected young people present with.
- Direct work needs to be underpinned by understanding of **diversity and of the impacts of inequalities**.
- Young people need **stability, continuity** and **persistence**. Frequent changes in social workers are unsettling. Young people prefer having **one key worker** who cares and does not give up on them when they disengage or act up.
- Support needs to be **flexible** and **high intensity**. Young people as well as their families value having access to 24/7 'on-call' support when they most need it.
- **Strength-based** approaches focus on young people's assets and build on these. Work should focus on **building resilience alongside reducing risk**.

DIRECT WORK SHOULD DRAW ON EVIDENCE BASED INTERVENTIONS

- **Trauma-informed** and **abuse-focused** interventions recognise the impact of CSE, alongside other adverse experiences, on the young person's psychosocial development and attachment. Interventions are usually longer and help address the underlying trauma resulting from, or increasing the risk to, CSE, which may be the root cause of a young person's health, mental health or behavioural problems.
- **CBT, DBT and (systemic) family-based interventions** have a **robust evidence base** in effectively addressing the needs of some vulnerable populations. CBT in particular can inform shorter term interventions to treat a range of disorders in a variety of settings. It is considered to have relatively high transferability and replicability.
- Evidence supporting the effectiveness of **relationship-based models** based on longer periods of engagement may seem to contradict research findings that suggest that a more targeted, goal-oriented and often shorter term **CBT-informed interventions can be equally or more effective**. But, in fact, both approaches have strengths and weaknesses. **Which model is more effective depends on how well it is suited to the specific needs of the young person and their ability to engage with a service.**

WIDER FEATURES OF EFFECTIVE RESPONSES IN DIRECT WORK

- **Viewing parents/carers as safeguarding partners.** Young people, parents/carers and families need support to be able to strengthen and rebuild their relationships. This can act as a protective factor that reduces the risk to CSE.
- CSE needs to be addressed through a **multi-agency response**. Information sharing protocols and meaningful risk assessments strategies are key.
- **Working in partnership** to meet young people's complex needs is important as is avoiding duplication.
- Direct CSE work needs **resilient practitioners**. Workers need ongoing **training and support**, including regular reflective supervision, team meetings and ongoing support (peer support from colleagues and debriefing sessions with managers/supervisors, etc.).
- **Longer term funding** (3 years+) and adequate resources create an environment that enables better quality direct work. Having **small enough case-loads** allows worker to provide high intensity work to young people affected by CSE.
- Improving working conditions is likely to **decrease staff turnover** and sick leave, which, in turn, ensures continuity and consistent relationships with young people.
- Having easily accessible (voluntary sector) services that are **independent** from social care/police is often valued by young people.

PART ONE: WHAT IS DIRECT WORK WITH YOUNG PEOPLE?

WHAT DOES DIRECT WORK MEAN IN THE CONTEXT OF CSE?

Direct work with young people can entail a variety of activities with the general goal of 'enabling young people to live constructively and to develop and grow' (Aldgate and Simmonds 1988; Robson 2010). It can be undertaken one-to-one or involve group work and may take place in a project or clinic, a school or a young person's home. The majority of direct work involves face-to-face interaction between a young person and a worker but it can be conducted via SKYPE or other forms of virtual media. Duration of work may vary from a few weeks to a year or more.

Much direct work with young people focuses on experiences of trauma, disruption, rejection and abandonment in their lives (Simmonds 1988; Scott and Skidmore 2006). At the therapeutic end of social work, there is a tradition of working with young people on their life histories in order to help them work through their feelings and understand the issues that may result from their life experiences. Such work often addresses trauma and attachment issues and may include working with a parent or foster carer as well as with the child.

The majority of direct work is referral-based, with referrals coming from another agency, schools, parents/carers or through self-referral. Depending how much information is available at the point of referral, direct work typically starts with a comprehensive needs and risk (and occasionally a resilience) assessment (e.g. ASSETPlus; YJB 2014).

There is usually a longer or shorter period of relationship building involving some informal contact. Following this engagement period, direct work is usually based on a verbal or written agreement between a young person, the service, and any others involved, that maps out a programme of work tailored to the young person's specific needs.

Interventions can comprise psychosocial education and prevention work, safety work, advocacy and recovery/therapeutic work – with different kinds of input sometimes provided by different agencies or by different professionals. For instance, youth workers may deliver socio-educative direct work in informal settings while structured, therapeutic work is more often undertaken by mental health or counselling services.

In Part Two of this review, we discuss the key stages and elements of direct interventions in more detail.

WHO ARE THE YOUNG PEOPLE CSE PRACTITIONERS WORK WITH?

YOUNG PEOPLE WITH MULTIPLE VULNERABILITIES

Practitioners who engage in direct work with young people who have been sexually exploited, or are thought to be at risk, see young people with a wide range of vulnerabilities and whose risks in relation to CSE may be variable and shifting (Scott et al 2017a). At the lower end of risk, young people may engage in risky online behaviour and interventions might focus largely on socio-educative prevention and safety work. However, these young people may have other vulnerabilities that are not directly related to sexual exploitation but which direct work needs to address.

At the high end of risk, young people are likely to be involved in abusive and exploitative relationships, exchanging sex for money or drugs, homeless and unsupported. In many cases, prior vulnerabilities contribute to the risk of sexual exploitation, but other problems then arise from this form of abuse (DH 2014). Common features in the lives of young people known to be affected by CSE include ruptures in family relationships, poor parenting, instability through frequent placement moves and isolation from peers (Scott and Skidmore 2006; Scott et al 2017a).

YOUNG PEOPLE LOOKED AFTER OR IN CARE

The majority of young people known to services because of concerns around CSE live at home with their families. Therefore, work with young people in care constitutes a relatively small proportion of direct work (Jago et al 2011; OCC 2012b). However, young people in care are disproportionately affected by CSE compared to their peers. This is partly as a result of the vulnerability resulting from prior abuse or neglect and sometimes because of additional risks they may face in the care system (Shuker 2013). Recent research on CSE-affected young people in care homes suggests that CSE-affected young people in residential care suffer from significant trauma due to CSE, which is, in some cases, compounded by other traumatic experiences such as neglect, physical or domestic violence (La Valle et al 2016). These young people are very vulnerable, with substance abuse, self-harm, depression, violent behaviour, low self-esteem, and sleep and eating disorders being common.

YOUNG PEOPLE WITH MENTAL HEALTH PROBLEMS

The Office of the Young people's Commissioner's Child Sexual Exploitation in Gangs and Groups (CSEGG) Inquiry (Berelowitz et al 2012/2013; OCC 2012a) reported that 85 per cent of sexually exploited young people interviewed either self-harmed or attempted suicide. Other issues included emerging personality disorder, borderline personality disorder, emerging psychosis, depression, suicidal ideation, drug and alcohol abuse, severe low self-esteem and self-neglect. While this work did not specifically investigate causes and effects,

i.e. exploring whether the mental health problems created vulnerability to CSE, or whether they were a result of CSE, or both, the study did show that a disproportionately high number of CSE affected young people also had poor mental health.

About half of all children and young people affected by child sexual abuse (CSA) suffer from depression, PTSD, disturbed behaviour, and/or attachment disorders, or a combination of these (Cawson et al 2000; OCC 2012a/2014; Monck and New 1996). Although some young people affected by CSE do not see themselves as exploited or abused, the emotional and psychological impact of CSE is that of an abusive relationship. Young people affected by CSE experience 'sexualised trauma' (Browne and Finkelhor 1986; Finkelhor and Bowne 1985) and the importance of practitioners working in ways that are 'trauma-informed' is increasingly recognised (Hickle 2016; Sweeney et al 2016; La Valle et al 2016). This is discussed further in Part Two (2.5) of the review.

ADDRESSING VULNERABILITIES THROUGH A TRAUMA-INFORMED, HOLISTIC AND TAILORED APPROACH

CSE needs to be understood in the context of adolescent development and the impact of trauma, neglect and abuse on the behaviour of young people in order to formulate adequate responses to their psychological needs (Webb and Holmes 2015; McNeish and Scott 2014). The complex histories of many exploited young people mean that their experiences are likely to have had an impact on their psychosocial development and/or attachment (McNeish and Scott 2014). Sexual abuse experienced early in life is associated with attachment difficulties, inability to trust adults and cognitive distortions about sexuality and relationships, which can lead to risky sexual behaviour and revictimisation (La Valle et al 2016). Shame and distress can lead to self-harm and depression and young people may resort to substance abuse in an attempt to numb their feelings.

Attachment disorders affect young people's psychosocial development and the ways they behave and relate to others (Shah 2015). Working with such young people is challenging and requires resilient workers who are adequately trained and supported to provide the consistent and ongoing relationships young people need (Webb and Holmes 2015). Evidence suggests that workers who have received training and engage in regular reflective supervision are more able to deal with the high demands of complex CSE cases (Webb and Holmes 2015; Scott et al 2017a; Williams et al 2017).

DIRECT WORK SHOULD BE UNDERPINNED BY AN UNDERSTANDING OF SOCIAL INEQUALITIES

The importance of placing young people at the centre of direct work, of listening to them and involving them in decisions made about them is widely recognised (Webb and Holmes 2015, Warrington 2013) and interventions that acknowledge a young person's layered and complex identity and that are tailored to their individual needs have been shown to yield better results (Smeaton et al 2015; Fox 2016; Cockbain et al 2014). Direct work therefore needs to be underpinned by an understanding of how different social inequalities, including

gender, sexual orientation, ethnic or faith background and (dis)abilities, intersect with CSE (Chase and Statham 2004).

GENDER

Boys and girls must deal with different issues in the process of becoming an adult man or woman in our society (Coleman and Hagel 2007). Girls and women with multiple vulnerabilities face a toxic trio of gender inequality, gender violence and gendered expectations that shapes their experiences, the ways they react to, and deal with their experiences and the ways in which systems and services they encounter respond to them (McNeish and Scott 2014).

Research into the sexual exploitation of boys and young men has shown both similarities and differences between males and females affected by CSE (McNaughton et al 2014). Research undertaken by NatCen and University College London (UCL) for Barnardo's identified that male service users were 2.6 times more likely to have a recorded disability than female service users (35% compared with 13%). Youth offending rates among service users were high: 48% of male service users and 28% of female service users had a criminal record. The figure for girls was particularly high when compared with offending rates for girls in the general population.

The research identified different routes into exploitative relationships for young men and the importance of masculinity and issues of sexual identity in understanding and supporting them. Professionals interviewed noted that boys and young men were more likely than girls to express distress externally as anger and be labelled as 'aggressive', 'violent', or an 'offender'.

SEXUAL ORIENTATION

Lesbian, gay, bisexual, transgender and/or questioning (LGBTQ) young people may feel isolated and believe there will be a lack of acceptance by other people regarding their sexuality and gender identity. In the absence of information and age-appropriate ways to explore their sexuality LGBTQ young people may seek support via adult orientated groups, online or, in the case of young men, in public sex environments such as 'cottages' or 'cruising grounds' (Fox 2016).

As many young people explore their sexuality and/or gender identity online they may be particularly vulnerable to online grooming for sexual exploitation .

Direct work with young people affected by CSE often includes parents/carers and families in safeguarding strategies. This can be difficult if there are negative attitudes towards homosexuality or strong demands for gender-role conformity in the family. In these circumstances, it may be appropriate not to disclose the young person's sexual orientation or gender identity to their family in order to keep them safe. This issue can be compounded

where the family's ethnic or faith background does not tolerate homosexuality and where disclosure may entail a risk of honour-based violence or forced marriage.

YOUNG PEOPLE'S ETHNIC AND FAITH BACKGROUNDS

Victims of sexual exploitation come from all ethnic backgrounds, regardless of how conservative or 'protected' young people may appear. There is a common media led public perception of victims of CSE being predominantly white, British girls from disadvantaged backgrounds (Fox 2016). However, Gohir's (2013) research demonstrates that Asian/Muslim girls and women are vulnerable to grooming and sexual exploitation from within their own communities and they have 'specific vulnerabilities associated with their culture which are exploited and also constitute a barrier to disclosure and reporting' (Gohir 2013).

Direct work needs to recognise and address the specific barriers young people from different minority ethnic and faith backgrounds face when thinking about how to identify and best support a child affected by, or at risk of CSE. This includes actively ensuring an understanding of the significance and gendered nature of concepts such as 'shame' and 'honour', the importance of 'virginity' or of heterosexuality as core to masculinity (Sharpe-Jeffs 2016). Whether, and how, workers may involve other family and/or community members in direct work are also important considerations.

Drawing on the expertise and 'reach' of specialist 'BME' agencies that are committed to violence-prevention or child protection, such as Southhall Black Sisters, IMKAAN and others, can assist with identification of victims, and help statutory and voluntary sector agencies provide better and more accessible services. However, recent work in this area suggests that approaches based on 'cultural competency'¹ training show little evidence that they positively impact client, professional and organisational outcomes (Elsegood and Papadopoulos, 2011; Horvat, Horey, Romios, and Kis-Rigo, 2014). Critics of the cultural competence approach have suggested that it tends to foster stereotypes and emphasise the 'otherness' of those outside the majority culture; directs attention to difference and diversity rather than inequalities and can reinforce the notion that it is peoples' culture that is 'to blame' for the difficulties they face (Danso, 2015; Powell Sears, 2012).

¹ Cultural Competence: a set of knowledge-based and interpersonal skills that allows individuals to understand, appreciate and work with families of cultures other than their own.

DISABILITIES

Direct work with young people at risk of, or involved in CSE, either as a victim, perpetrator, or both, should consider how 'disability' interlinks with young people's psychosocial development and how it shapes their safeguarding needs. The abuse of young people with disabilities has been fairly invisible for much of history and there are still many gaps in knowledge with regard to how disability intersects with other abuse-related risk factors.

A study conducted by the NSPCC found that young people with a disability are three times more likely to be abused than young people without a disability (Miller and Brown 2014). Research suggests that disabled young people in residential care are at particular risk of all types of abuse, including sexual abuse and abuse from peers and carers (Utting 1997; Kvam 2004; Sullivan et al 1987).

A significant number of young people with harmful sexual behaviour have been shown to have learning difficulties or disabilities (Miller and Brown 2014). Hackett et al (2013) examined the individual, family and abuse characteristics of 700 British child and adolescent sexual abusers and found that in 38 per cent of cases where disability status was noted, the child was identified as having a learning disability. Conversely, learning difficulties or delayed development may be a consequence of trauma or sexual abuse (Smeaton 2015; Fox 2016). A lack of diagnosis and assessment for learning disabilities can result in a young person's behaviour being misunderstood and may lead to exclusion from school, which can, in turn, increase a young person's vulnerability to CSE.

While becoming knowledgeable about individual kinds of inequalities is important, the reality is that most of the families and children that front line workers will encounter will be struggling with multiple layers of disadvantage linked to interlocking social positions. Simply thinking about a young person's gender, ethnicity or class is clearly inadequate when their lives and experiences are shaped by multiple and intersecting power relations (Allen and Jaramillo-Sierra, 2015). On the other hand, it is unreasonable to expect workers to be well informed about the backgrounds and possible experiences of all potential clients. It is, however, achievable for staff to become consciously aware of their own backgrounds, the ways they are privileged and disadvantaged by the structural inequalities that have shaped their lives, and that impact on how they relate to people. This is supported by research findings (Keyser, Gamst, Meyers, Der-Karabetian, and Morrow, 2014). There is also evidence that clients don't expect workers to be hugely knowledgeable about their particular cultures and backgrounds, or to speak their language. What they do expect is respect, an open attitude, and genuine interest and willingness to learn (Jack and Gill, 2013).

At the very least young people need to be given safe opportunities to talk about what it means to them to be e.g. a young person of a particular gender, sexual preferences and social location. Workers need to ask questions that allow them to speak about what matters to them in terms of their lived experience of the intersections of gender, race, class and

sexuality, including the implications for their identity, and to work with them in teasing out the sources of conflict and difficulties. This means that some workers may need training and support to overcome any reticence they may have about initiating conversations that might seem difficult or potentially cause distress.

PART TWO: DIRECT WORK IN PRACTICE

WHAT ARE THE CORE ELEMENTS AND PRINCIPLES OF DIRECT WORK?

WHAT ARE THE PRINCIPLES UNDERPINNING GOOD CSE PRACTICE?

The literature suggests that there are a number of good practice principles that should inform the development/redesign of CSE services. The Research in Practice (RIP) evidence scoping 'Working effectively to address Child Sexual Exploitation' identifies six elements as central to effectively understanding and addressing CSE. These are:

1. Young people must be at the centre.
2. CSE is complex; therefore, the response cannot be simple or linear.
3. No agency can address CSE in isolation; collaboration is essential.
4. Knowledge is crucial.
5. Communities and families are valuable assets, and may also need support.
6. Effective services require resilient practitioners.

(Webb and Holmes 2015)

WHAT ARE THE CORE ELEMENTS OF CSE DIRECT WORK?

Despite the considerable range of models that are currently used in direct work with young people, interventions usually involve the following core elements:

CORE ELEMENTS OF DIRECT WORK WITH YOUNG PEOPLE EXPLOITED OR AT RISK (Scott, 2017)



The process of direct work is not linear as practitioners may move back and forth between the different components or work on several elements simultaneously.

ENGAGEMENT AND BUILDING RELATIONSHIPS: HOW CAN EFFECTIVE ENGAGEMENT FACILITATE DIRECT WORK?

There is usually an initial period of building trust and establishing communication and understanding between young person and worker before other work can begin. This period can last from a couple of weeks to many months, depending on both the commissioning/contractual agreement with funders /service provider and the willingness of

the young person to engage. The literature notes the significance of a young person's 'readiness to change' (La Valle 2013), which can be an important prerequisite for engagement and increases the chance of direct work being helpful.

RIP practice guidance on working with CSE-affected young people recommends that young people should be active agents in the therapeutic relationship rather passive recipients of a service (Webb and Holmes 2015). Practitioners report that it is important not to push young people too hard during this initial period, and allow them to decide when they are ready to address issues, particularly with work that focuses directly on CSE or other traumatic experiences. Involving young people in decision-making and problem solving in other key areas of their lives as well as in setting the agenda and pace of direct work is considered to facilitate engagement (Aldgate and Simmonds 1988).

A research review (Mason and Prior 2008) on effective engagement with youth offenders showed that, amongst other things, effective interventions:

- are based on careful assessment;
- link interventions to established need and thus are tailored to the individual, using a risk and protective factors framework;
- include an element that focuses upon cognitive skills²;
- are multi-modal and address different aspects of the young offender's behaviour or lives, for example by working with the family as well as providing a range of direct support, and with elements that are co-ordinated or interrelated;
- are delivered as designed and are based on evidenced-based programmes;
- have long-term engagement and contact time (the greater amount available, the greater the impacts), particularly for persistent and more serious offenders; continuity of contact is important.

These findings are relevant to direct work with young people affected by CSE and support some of the good practice principles outlined on page 13 above (Webb and Holmes 2015).

HOW DO RELATIONSHIP-BASED MODELS FACILITATE TRUST AND ENGAGEMENT?

Establishing and maintaining a trusting relationship, based on mutual respect and honesty, features as a key theme in successful practice (Factor et al 2001; OFSTED 2014; Webb and Holmes 2015) and has also been evidenced in an evaluation of the NSPCC's LETTING THE FUTURE IN (LTFI) service for young people affected by sexual abuse, which involved the largest randomized controlled trial (RCT) of its kind (Carpenter et al 2016).

² Cognitive Behavioral Therapy (CBT) is frequently used in direct work with young people who offend, or are at risk of offending. CBT has an extensive evidence base demonstrating its effectiveness in a variety of settings, including youth offending (see 2.5).

While there may sometimes be differences between CSA and CSE relating to issues around the developmental stage at which the abuse occurs and the child/young person's sense of agency, there are strong similarities in the use of deception and abuse of trust which are integral to the 'grooming' process, peer on peer exploitation and the 'boyfriend' model of sexual exploitation (Pearce 2009; Webb and Holmes 2015).

Example 1: Letting the Future In (NSPCC)

LTFI is a service for young people aged 4 to 17 years who have been sexually abused. It was developed by the NSPCC and has been implemented by 20 teams since 2011. The service helps young people come to understand and move on from their past experiences through activities such as play, drawing and painting and storytelling. It is grounded in an understanding of trauma, attachment and resilience. Young people receive up to four therapeutic assessment sessions followed by up to 20 intervention sessions. The average number of individual sessions young people receive is 14.2, with some young people receiving up to 36 individual sessions (Carpenter et al 2016). Parents/carers are offered help with the impact of discovering that their child was sexually abused, and to support their young person's recovery.

Bannister's (2003) psychodynamic 'Recovery and Regeneration model', which underpins LTFI, emphasises the therapeutic attunement of the worker to the young person's affective states (Carpenter 2016). According to Bannister, sexual abuse is a form of betrayal:

'one of the effects of betrayal is the inability to trust, and since trust is at the heart of the therapeutic relationship this feeling can inhibit even the start of useful work.'
(Bannister 1998)

Gaining a young person's trust is a vital precursor to successful engagement and the foundation upon which direct work is built (Aldgate and Simmonds 1988). Engagement and relationship-building usually requires a practitioner to give a child consistent attention over a period of time. This may be harder to achieve through time-limited interventions (that are underpinned by a shared understanding between the child and the worker of short-term outcomes to be achieved), such as Cognitive Behavioral Therapy (see 2.5).

WHY IS 'THERAPEUTIC ALLIANCE' IMPORTANT?

The relationship between a practitioner and client is sometimes referred to as 'therapeutic alliance' and the strength of the alliance can be used as a measure³ to assess the

³ Therapeutic Alliance Scale for Young people or 'TASC'

effectiveness of interventions (Shirk and Saiz 1992). Bannister's Recovery and Regeneration model is built on the assumption that trust has to be built and that, with trust, the strength of the therapeutic alliance will increase, which will, in turn, have a positive effect on outcomes for young people (Carpenter 2016).

The evaluation of LTFI found consistently positive feedback on the therapeutic alliance and highlighted this to be a vital contributing factor for effective direct work with young people affected by sexual abuse.

Young people who completed the programme and their carers reported benefits in terms of:

- Improved mood.
- Better confidence.
- Reduction in guilt and self-blame.
- Reduced depression, anxiety and anger.
- Improved sleep patterns.
- Better understanding of appropriate sexual behaviour.

(Carpenter et al 2016)

Overall, the evaluation of *LTFI* shows some promising results:

- Almost three-quarters (73%) of young people aged 8 and over who completed 6 months of *Letting the Future In* had severe emotional difficulties at the start. After 6 months, this dropped to less than half (46%).
- When taking into account the young people who didn't engage or dropped out of the service early the number of young people experiencing severe trauma dropped from 68% to 51%.
- There was no comparable change for young people in the control group (a 6 month waiting list). This indicates that the positive outcomes were a result of receiving the service.

One significant finding of the evaluation was that the results for teenagers were much better than for those under 12 (Carpenter et al 2016). They were impressive for those who stayed in treatment but there were high levels of drop out. The RCT also revealed that over half of older young people, and around one third of younger children had experienced three or more types of victimisation, such as physical and verbal abuse at home and bullying by other young people, in addition to the sexual abuse. This reinforces the need for direct work to adopt a holistic approach that addresses the specific, and potentially multiple, needs and vulnerabilities of the young person as these can intersect with, and increase the risk of CSE.

INCREASING SUPPORT AND STABILITY: HOW CAN DIRECT WORK ENSURE SUPPORT AND STABILITY?

Estimates suggest that one third of sexually exploited young people are 'looked after' (Community Care 2011). While the majority of CSE affected young people live with their families, 'Reducing the Risk' noted a clear deficit in the parenting capacities of many young people's parents and relationships with fathers were frequently poor or non-existent (Scott and Skidmore 2006). At initial assessment 46 per cent of those identified as acutely sexually exploited had little or no communication with their carers, and 28 per cent had poor communication. Although some young people received support from other relatives, many depended entirely on professionals for adult support. In the absence of parental support in adolescence, many young people had made a premature move into adult lifestyles where they became an easy target for 'risky' adults. Such evidence points to the need for 'family work' and support for parents to accompany any direct work with young people affected by CSE.

Sexually exploited young people need a relationship with a key, consistent professional who is on and by their side (Berelowitz et al, 2013; Foley et al 2004). Research suggests that vulnerable young people want 'honest, trustworthy and transparent services' (Warrington 2013) and need the consistent, reliable support of a worker who does not give up on them but who persists and shows them that they genuinely care and will be there for them (Smeaton 2013). This is particularly important as young people's exploitation may be ongoing, their engagement with the service may be inconsistent, they may not turn up to sessions or they may stop returning their worker's calls.

WHY ARE KEY WORKERS INSTRUMENTAL IN PROVIDING STABILITY?

OFSTED's (2014) thematic inspection on the effectiveness of local authorities' current response to child sexual exploitation revealed that the most significant concern that young people expressed to the inspectors was the frequent changes in social workers that many experienced. Young people felt that changes of social workers compounded already existing trust issues, as one child explained:

'My social worker does listen to me but I have been in care for nine years and I have had a different social worker for every year. They say you can trust them but... it gets really hard to trust people.' (OFSTED 2014)

Some young people report feeling alienated by having too many different professionals in their lives and find frequent changes in social workers unsettling (Scott 2017a). Instead, young people tend to prefer the long-term support of one key worker who listens, does not judge, is consistent and who shows that they care. This finding is well established in wider research, including the Munro Review (2011).

HOW CAN KEY WORKERS PROVIDE CHILD-CENTRED, FLEXIBLE AND HIGH INTENSITY SUPPORT?

Example 2: The 'Achieving Change Together' (ACT) Model

The ACT Innovation project in Wigan and Rochdale has recently piloted a model based on the flexible, high-intensity provision of one key worker who worked with an at risk child alongside their social worker and parents/carers in order to avoid placement in high-cost or secure accommodation (Scott 2017a). The small-scale pilot gave insights into the type of support young people affected by CSE want.

Findings indicate that **young people rated their key worker highly** because they viewed them as someone who cared about them and didn't tell them what to do all the time. They appreciated having someone to talk things through with and also to have fun with. Young people particularly valued that workers were honest with them and 'stuck around' even when they acted up. The **intensity of support** and the **accessibility of their workers** was highlighted as particularly significant. Young people also valued their worker's persistence and positivity as they focused on possibilities rather than problems:

"X is different, we have a laugh, we chill. She doesn't make negative comments about what I am doing, she focuses on the positive. She moves forward."
(Young person in Scott 2017a)

The ACT evaluation found that the accessible, flexible and high-intensity support of a key worker helped more young people to remain at home or in stable placements (Scott 2017a). In the first 8 months of operation ACT provided intensive early support to 25 young people, mainly young women under 16, affected by CSE, home or placement instability. None of the young people living at home and judged to be 'on the edge of care' were taken into care, and no child in care moved into high cost or secure placements (Scott 2017a).⁴ This was achieved by:

- Providing high intensity support when needed.
- Working non-conventional hours in order to meet young people's needs.
- Delaying assessment until a child is engaged.
- Engagement taking as long as is necessary to build trust.
- Focusing upon young person's needs and goals.
- Using technology to engage and 'speak' to young people.⁵
- Developing a child friendly strengths based assessment.⁶

⁴ Only two young people were moved into other placements that better met the child's needs and these transitions were supported by the ACT key worker.

⁵ ACT has produced an 'augmented reality' card with service information and contributions from a child, parent, foster carer and worker. It is accessed via a Zappar application on iPhone or Android devices.

- Promoting young people led meetings.
- ACT social workers being key workers and leading care planning.
- Key workers acting as a bridge between young people's social workers and parents/carers.
- Minimising the number of professionals around the child.

It is important to note that the early success of the ACT model was underpinned by a significant amount of resources that allowed social workers to handle smaller caseloads than normal.⁷

HOW CAN WORKERS SUSTAIN CONSISTENT AND HIGH QUALITY DIRECT WORK TO ENSURE STABILITY?

Working with young people who have been abused and exploited can be challenging. The strains that such work can put on professionals is well documented (Munro 2011; Webb and Holmes 2015; Lane et al 2016). CSE workers may face a range of challenging behaviours and attitudes from a child, including anger/abuse; aggression/projection; rejection/denial and avoidance; testing, particularly if they have been let down by services before (Pearce 2009).

Example 5: 'Safe Steps' CSE Innovation Project

The evaluation of the *Safe Steps* CSE Innovation Project, which piloted a social pedagogy-informed model of working with CSE-affected young women in high protection/supervision young people's homes in London, revealed the considerable emotional impact of residents' challenging behaviour on staff (Williams and Scott 2017). Staff had to manage unpredictable, aggressive and violent situations and some sustained injuries. Staff also had to handle disclosures, and while it was a good sign that residents were opening up and talking about their experiences, it could be stressful:

"She burst into tears; she spoke about being raped many times. Even with my length of experience I was struggling"

(Residential worker in Williams and Scott 2017)

⁶ Currently being developed as an 'adolescent strength and participatory based assessment tool' to be launched with the pathway in January 2017.

⁷ Although all have been highly complex and demanding cases, the caseloads of ACT social workers have been approximately a third of those of other young people's social workers in Wigan and Rochdale. There is a question about whether social workers with larger and more mixed caseloads could provide the same level of relationship-based support in those cases where it was required.

WHAT ARE THE TRAINING AND SUPPORT NEEDS OF WORKERS DELIVERING DIRECT WORK?

Practitioners need adequate training, ongoing and high quality support and regular supervision, including supervision to ensure self-reflective practice. Evidence suggests that this is crucial to sustain effective work with young people affected by CSE (OFSTED 2014; Webb and Homes 2015). One example of providing support to practitioners is the MAC UK Integrate model and 'team around the worker' style of working, which promotes both the development of a strong relationship (therapeutic attachment) between a child and a key worker and high levels of peer support across a team of workers (see www.ashoka.org UK; Scott 2017b, Appendix 4).

The need for high quality training and flexible and ongoing support also extends to other people who directly support a child affected by CSE, including foster carers. The evaluation of Barnardo's 'Safe Accommodation Project for Sexually Exploited and Trafficked Young People' describes how, in addition to training, specialist foster carers in the project received support from the supervising Local Authority social worker and a Barnardo's CSE project worker, who was supporting the child but was also available to the carer (Shuker 2013). Findings from the evaluation showed that foster carers particularly valued the 24/7 nature of the support and appreciated that they could always speak promptly to someone who knew and understood their cases, even if their assigned social worker was not on call.

HOW CAN DIRECT INTERVENTIONS STRENGTHEN STABILITY AT HOME?

Because of the strong link between CSE and going missing (Smeaton 2013), ensuring stability in the home and school environment can be a central focus of direct work. Evidence suggests that young people involved in CSE often have challenges in their home environment, yet, research also highlights the positive role families can play in reducing a young person's risk to CSE (Scott and Skidmore 2006; D'Arcy et al 2015). Findings from the ACT pilot (Example 2 above) highlight that parents/carers require timely support and understanding from someone outside the family (Scott 2017a). The evaluation further demonstrated that workers can enhance young people's relationships with their parents/carers by supporting open communication with their family. Adopting a strengths based, family-centred approach to involving parents/carers is therefore an important aspect of direct work with young people affected by CSE.

There are a number of different models of involving parents, carers and other stakeholders in the wider community in efforts to prevent and reduce the risk of CSE. These models have different approaches and theoretical underpinnings and some have been evaluated. While a detailed discussion is outside of the scope of this review, we describe a small selection of approaches here (Examples 3; 4; and 5) to highlight how direct work with parents/carers and families can be beneficial in reducing risks, and strengthening resilience to CSE.

Example 3: The 'Positive Parenting Program' (Pathways Triple P)

Pathways Triple P draws on cognitive behavioural and development theory and aims to show parents how their behaviour can improve their relationship with their child. It is based on the principle of self-modelling and uses Video Interaction Guidance (VIG) that allows parents to watch themselves behaving in a positive way (Dorwick 1999). VIG is based on the belief that even in difficult situations everyone has the power and capacity to change. Parents can decide what they want to change and set specific goals. VIG practitioners then use video to show positive moments during parent-child activities and help parents build on these moments to make a stronger bond with their child (Whalley and Williams 2015).

The evaluation of Pathways Triple P illustrates that direct work with families can facilitate relationship building between a child and their parents/carers (Whalley and Williams 2015). Although Triple P is not an intervention that specifically addresses CSE, it has been shown to improve relationships between parents and young people and to reduce problems with young people's behaviour (Wiggins et al 2009).

Research has shown that VIG is effective at changing behaviour and attitudes (Fukkink 2008) and reaching parents who are not motivated to change, including families where there is concern of neglect or other forms of child maltreatment (Chaffin et al 2009).

Helping young people to reconnect and build positive relationships with their family and wider support system is critical in supporting a child at risk of CSE, as the Families and Communities against Sexual Exploitation (FCASE) evaluation (Example 4) has also shown (D'Arcy et al 2016).

Example 4: Families and Communities Against Sexual Exploitation (FCASE)

Barnardo's FCASE project was piloted as a model that engages key people around young people at risk of CSE, including parents and families, local business and the wider community in direct work and awareness raising activities. Separate workers are provided for parents/carers and the child to enable families to build on their strengths in order to prevent and support those affected by, and at risk of, CSE.

The pilot evaluation confirmed that FCASE is a positive model and demonstrates the value of:

- Working with parents and carers alongside young people using a **strengths based approach**.
- Equipping families with the knowledge and information to help them safeguard their young people.
- Promoting the role of the voluntary sector in 'building bridges' between families and statutory services.
- Engaging workers with specialist knowledge, relational skills, and **family centred/victim centred** working.
- Assigning separate **key workers** to parents/carers and young people.
- Providing **continuity** of workers in **building trusting and productive relationships**.
- Ensuring **flexibility** of meetings and sessions with families and young people.
- Promoting 'Safer You' family meetings as important spaces for resolving conflicts, improving communication and devising action plans that increase protective factors.

Involving key people in the young person's environment can help to build a protective network around the child at risk (Aldgate and Simmonds 1988). The NICE guidelines (2005) on treatment for individuals with PTSD recommend involving parents/carers and families in therapeutic work with young people. This is also an integral element of the relational safeguarding model developed by PACE (Example 5).

Example 5: The Relational Safeguarding Model (PACE 2014)

The relational safeguarding model focuses on:

- Maximising the capacity of parents/carers to safeguard their young people and contribute to prevention, disruption and conviction of perpetrators.
- Early intervention and prevention.
- Involving families in safeguarding processes around the child, including decision-making.
- Ensuring the safety and wellbeing of the family in recognition of the impact of CSE.
- Balancing the child's identity as both an individual and as part of a family unit.

In order to minimise the risk of conflict between parents and agencies in regards to safeguarding measures, parents and families are supported by a co-located Independent Parent and Family Support Worker (IPSW) who is employed by an outside agency rather than social services or the police. The IPSW is an integral part of working as part of a multi-agency team within the framework of the relational safeguarding model and has shown to provide benefits in terms of:

- Safeguarding young people.
- Improving parents and family engagement with statutory agencies.
- Successful prosecutions of perpetrators.
- Empowerment of parents to provide the long term support of the victim.

(PACE 2014)

The standard child protection model is based on the assumption that parents may be (partly) responsible for the abuse or neglect that a child is experiencing (DH 2000; PACE 2014). While this framework may suit the context of sexual abuse and other forms of child maltreatment within the home, it does not adapt well to the specific context of CSE, where external perpetrators may pose the greatest risk (PACE 2014). This presents a challenge for agencies and requires a dual approach to direct work with parents/carers: they should be treated as safeguarding partners yet at the same time they need support for their own wellbeing and to support their child. This is particularly vital as the impact of grooming for sexual exploitation can infiltrate the young person's home dynamics and corrupt the relationship between the child, parents and siblings. Parents or other family members may be the first to recognise that something is wrong and need support to safeguard their child. This is why family-based models of direct work can be an effective approach to managing a young person's risk to CSE.

PROVIDING ADVOCACY: WHAT ROLE DOES ADVOCACY PLAY IN DIRECT WORK?

'Advocacy' typically entails the support of a trusted worker to advocate for young people and help them understand and manage the different agencies, relationships and appointments in their lives. The role of the advocate is to navigate multi-agency involvement and to establish which the most beneficial intervention is for the child at the time – and to find out what young people want. Advocacy can reduce young people's anxiety and help them gain the confidence and skills to eventually advocate for themselves. Advocates may assume the role of a young person's key worker or work alongside other professionals and different agencies.

Example 6: The Youth Advocacy Program's 'wraparound' model (YAP Inc.)

YAP is a model of youth advocacy developed in the U.S. that assists individuals and families across a continuum of needs. It provides intensive support to young people and their families within their homes, school and community through a 'wraparound-advocacy model' - an intensive, individualised, holistic care planning and management approach to working with high and complex need young people and families (YAP INC).

YAPs are mostly intensive and short term. While the average length of program involvement is 17 weeks, almost a quarter of young people stay in YAP for more than 24 weeks (John Jay College of Criminal Justice 2014). YAP advocates work directly with young people and their families for an average of 47 days whilst over 20 per cent of young people receive 70 contact days or more .

YAP has been extensively evaluated in a variety of settings, including juvenile justice, employment and education, and considers itself a 'best practice model' for meeting the complex needs of highly vulnerable populations. Compared with other young people in the child welfare and juvenile justice systems, YAP participants have:

- Higher program completion rates.
- Lower rates of placement into residential foster care.
- Lower re-arrest rates.
- Low numbers of young people who are AWOL.
- Greater residential stability.

YAP can be tailored to different groups of young people, including girls, different black and ethnic minority groups, or young people with experiences of trauma.

YAP Inc.'s 'Commercially Sexually Exploited Young people' (CSEC) program is marketed as a 'cost-effective alternative' to detention or placement that meets the needs of sexually exploited young people within their homes and communities. Program components include engagement (with child and their family), holistic and individualised youth-led plans, flexible and intensive support, court advocacy and youth empowerment and healing (YAP Inc.). It offers the well-researched 'MY LIFE, MY CHOICE' program, a 10-session curriculum that is led by a certified trainer and Survivor Mentor who has escaped the commercial sex industry, to help young people build the skills, knowledge and attitudes necessary to empower them to make safe, healthy choices.

WHAT DOES ADVOCACY FOR VICTIMS AND SURVIVORS OF SEXUAL VIOLENCE LOOK LIKE?

In the UK, advocacy to young people and young people affected by sexual violence is delivered in different ways. The Barnardo's '4 As' model describes 'advocacy' as

'a range of services (that) are needed to build a protective network around young people. Staff help young people get access to the services they need and advocate for them when relationships with other services break down.'

(Barnardo's 2009)

Other forms of advocacy include the 'Child House' model (based on the Icelandic Barnahus model), which is currently being piloted in London with another pilot being envisaged in Durham (OCC 2016). Sexual Assault Referral Centres (SARCs) and advocacy services provided by voluntary sector organisations like Rape Crisis (Barnardo's; OCC 2016; Robinson and Hudson 2011) are engaged in the pilot. The majority of advocacy work, except for the Barnardo's model, are not specifically tailored to CSE but relate to sexual violence more generally (e.g. SARCs, Rape Crisis), or are focused primarily on child sexual abuse ('Child House').

INDEPENDENT SEXUAL VIOLENCE ADVISORS (ISVAs)

ISVAs are generally recognised to work well in the context of sexual assault and rape and the tailored support of an ISVA may also benefit young people affected by CSE (see Smeaton, 2016). However, as CSE is rarely a one-off event and may not be recognised by the child as abusive or exploitative behaviour, there are additional challenges specific to CSE that need to be addressed.

Example 7: Independent Sexual Violence Advisors (ISVAs)

A significant development within direct work with victims of sexual violence has been the introduction of Independent Sexual Violence Advisors (ISVAs) who provide advocacy and support to victims (HM Government 2010, 2011a, 2011b). The funding and development of ISVAs in sexual violence services stemmed from mounting **evidence of the effectiveness of victim advocates** within other settings, for instance domestic violence (Independent Domestic Violence Advisors 'IDVAs') (Cook et al, 2004; Howarth et al 2009; Parmar et al 2005; Robinson 2003, 2006). ISVAs support the victim with information, advice, support and guidance that is specifically tailored to the victim's needs (Robinson and Hudson 2011). Independent of any organisational mandate, ISVAs provide **crisis intervention** and **non-therapeutic support** from time of referral, **information** and **assistance through the criminal justice system** (CJS) alongside offering **practical support** and **advice**. The role of the ISVA is to prioritise the **needs of the victim**, to reduce the victim's uncertainty over the criminal justice process and to support the victim's participation in criminal justice proceedings and in the development of their own care plans. Since their introduction in 2006, ISVAs have been recognised as key workers in both SARCs and voluntary sector projects and constitute an example of providing direct work through a holistic and tailored approach that addresses the multiple needs of victims.

Robinson's (2009) process evaluation of ISVAs suggests that ISVAs had enabled victims to 'pull through' the aftermath caused by sexual violence. **Victims appreciated having one key worker who 'did everything'** and tailored support to their needs as an individual.

REDUCING RISKS AND INCREASING RESILIENCE

Reducing risks is a core element of direct work with young people affected by CSE and, in practice, often goes together with building resilience (Coleman and Hagel 2007). Making sound judgements about a young person's level of risk can be challenging and depends on the nature and quality of information that is available to the practitioner at the point of referral. Effective information sharing across agencies is key to facilitating sound risk assessments and avoiding duplication.

HOW CAN INFORMATION SHARING ENHANCE RISKS REDUCTION THROUGH DIRECT WORK?

Adequate risk assessments rely on effective information-sharing agreements between different agencies and a joint-up approach to strategic support. Safeguarding is the responsibility of all those who come into contact with young people and young people and relies on professionals and agencies to have a clear understanding of the unique contribution they are making to the whole system (Webb and Holmes 2015a). OFSTED (2014) calls for all partners to take responsibility for their role as a discrete agency, work collaboratively with each other and have a shared understanding of how to tackle CSE. This principle is embedded in a multi-agency approach to addressing CSE:

EXAMPLE 7: A MULTI-AGENCY APPROACH TO RISK ASSESSMENT/REDUCTION

Co-locating operational teams and/or Multi-Agency Safeguarding Hubs (MASHs) can facilitate early information sharing, as can alternative partnership arrangements or 'virtual teams' (DH 2014). As healthcare professionals often hold key information, it is crucial that they are involved in developing effective risk assessments and responses. Effective early intervention requires working together across agencies and teams, for instance, through establishing Multi-Agency Sexual Exploitation (MASE) meetings (DH 2014).

This is to ensure that young people affected by CSE have easy access to health and sexual health services in addition to receiving services for the broad range of physical and mental health problems they may have. Recommendations from the Health Working Group on CSE further include establishing clear, local CSE/CSA care pathways with clear decision-making points, for instance, referring to local SARCs or other specialist service providers that may be located in the voluntary sector (DH 2014; Robinson and Hudson 2011).

In addition to effective multi-agency approaches, the literature highlights the importance of involving young people in discussions around risks. This can significantly contribute to getting risks assessments right and can help to develop effective risk reduction strategies that are tailored to the individual child.

Learning from the *Safe Steps* pilot, for instance, stressed the importance of training staff to take a young person's full history as a basis for risk assessment, as referral information is often out of date and rarely provides information about the young person's strengths (Williams and Scott 2017).

WHY AND HOW SHOULD YOUNG PEOPLE BE ACTIVELY INVOLVED IN RISK REDUCTION?

Practitioners highlight the importance of understanding young people's needs and really listening to young people. The CSE measurement tool developed by The Greater Manchester Phoenix CSE Service (Appendix 2) ensures that young people are consulted and their wishes, their level of understanding and their willingness to engage is considered as part of the risk assessment. Involving young people in discussions around risk reduction enables practitioners to better understand the young person's situation and level of risk, and simultaneously, may enhance the young person's understanding of the risks associated with CSE. This helps lead them to better understand the rationale and potential outcomes of their engagement with direct work.

Young people may struggle to identify behaviours and relationships as abusive and may not see themselves as 'at risk' or exploited. Helping young people to gain a better understanding of what constitutes a 'healthy' or 'unhealthy' relationship is crucial in building their capacity to manage risks independently and to make more informed choices about their own safety. Direct work therefore often pursues a dual focus: to build resilience alongside reducing risks. This may entail psycho-educational sessions and prevention work in schools or centre-based activities. Such work typically focuses on consent, grooming, safe relationships, online safety, discussions around sexual health strategies and substance or alcohol misuse as well as on reducing episodes of missing and associating with risky peers and adults.

HOW CAN RESILIENCY THEORY INFORM DIRECT WORK?

Resiliency theory is a strengths focused approach to understanding why some young people grow up to be healthy adults in spite of risks exposure (Garmezy 1991; Masten et al 2007; Rutter 1987; Werner and Smith 1982). It focuses on positive contextual, social, and individual factors that interfere with, or disrupt, developmental trajectories from risk to problematic behaviours and/or poor health and mental health outcomes (Zimmerman 2013). These positive factors are often referred to as promotive/protective factors, which counteract risk factors and help young people overcome the negative impact of risk exposure and adverse experiences. Fergus and Zimmerman (2005) identified two types of promotive factors: 'assets' and 'resources'. Positive factors that reside within individuals, such as self-efficacy and self-esteem, are defined as 'assets'. Positive factors that reside outside individuals, such as parental support, adult mentors, and youth programs that provide young people with opportunities to learn and practice skills, are considered 'resources'. Both 'assets' and 'resources' can contribute to healthy development and build resilience.

In practice, direct work may use a strengths based approach during all stages of the journey with vulnerable young people. Many therapeutic models, including those we discuss in section 2.5, draw on resiliency theory and incorporate strength based elements. This is

because resilience is widely accepted to play a crucial role in preventing and/or reducing risks to (re)victimisation as well as enhancing an individual's ability to recover from trauma.

HOW CAN DIRECT WORK BUILD RESILIENCE?

Current evidence on the factors which promote resilience⁸ suggest that young people and young people need to have:

1. At least one trusted adult who they know cares about them and who helps them through life
2. Support with the basics of food, clothes, transport and housing
3. Access to activities that offer fun and excitement
4. Opportunities to practise problem-solving in different situations
5. Places and spaces where they feel safe and can be themselves
6. Support to understand and manage their feelings
7. A chance to find things they are good at and that make them feel proud of themselves
8. Opportunities to help other people
9. Support which recognises their whole lives: at home, at school and in the community
10. A sense of hope and ambitions for the future

Coleman and Hagel (2007) have argued that 'being there' for young people and building a relationship with them is the most effective professional approach for building resilience. Research reviews identify several factors that can support resilience and recovery from trauma in adolescence and early adulthood, including: establishing or maintaining a strong, supportive relationship with a parent/carer and with a committed, reliable worker outside the family; maintaining the positive supports of extended family and friends (by keeping young people local) and re-engaging them in education (Coleman and Hagel 2007; Newman 2004).

WHAT IS THE EVIDENCE BASE OF STRENGTH BASED APPROACHES?

The benefits of using a strength based model of working with young people affected by CSE have been well established by previous research (Pearce 2009/2007; OFSTED 2014). Evidence further suggests that a strengths based approach is also beneficial in direct work with families in the context of CSE. Focusing on building strengths rather than identifying weaknesses and harm, can enhance the relationship between young people and their families and build resilience (Newman 2011; PACE 2014; Webb and Holmes 2015).

⁸ See Hart, A. and B. Heaver. 2015 Resilience Approaches to Supporting Young People's Mental Health: Appraising the Evidence Base for Schools and Communities Brighton; University of Brighton/Boingboing

Using a strengths based approach, such as YAP (Example 6), have been shown to effectively meet the needs of high-risk populations.⁹ The YAP ‘wraparound model’ has been tested in a variety of settings, including employment, juvenile justice and education, both in the US and internationally (YAP Inc.; John Jay College of Criminal Justice 2014). Evaluations of YAP programs demonstrated several measures of success, including:

- Achieved reductions in risks and needs.
- Improved quality of life.
- Positive results in education.
- Enhanced links with community activities.
- Improvements in social behaviour.

Findings from YAP in the juvenile justice setting suggest that involvement in YAP keeps clients engaged in pro-social activities, which reduce the likelihood of re-offending. Connecting young people with pro-social activities and influences in their own community also increases the likelihood of them remaining positively engaged after the program ends (John Jay College of Criminal Justice 2014).

The role of direct work in enhancing young people’s resilience, confidence and self-efficacy by engaging them in positive social activities, training and education are particularly important when direct work comes to an end as it helps to transition them into independence from services, which is highlighted in section 2.6.

ADDRESSING UNDERLYING ISSUES

Addressing the underlying issues that increase vulnerability to, or result from sexual exploitation, is a core component of direct work that usually involves looking at a young person’s trauma history and attachment issues.

TRAUMA-INFORMED DIRECT WORK

Repeated encounters with trauma and stress have serious consequences for the physical, social, and emotional wellbeing of young people. If left untreated, traumatic experiences can have lasting repercussions (Klein and Klain 2013). In the immediate and long-term

⁹ For example, juveniles tracked in the Philadelphia study reported high service needs, low self-esteem, low levels of school and family bonding in comparison to similar programs that were evaluated. In addition, youth in the YAP’s Tampa program were more likely to have had a history of outpatient mental health treatment, a history of running away, a history of family violence and a history of substance abuse in their biological families than comparable programs. Youth in the Tampa program were also less likely to have received school based mental health services or alcohol or substance abuse treatment prior to intake. Finally, in YAP Pennsylvania programs for youth with disabilities over 37% of the youth studied have autism.

aftermath of trauma, young people are at risk of developing significant emotional and behavioural difficulties (Berliner and Elliott 2002; Briere and Elliott 2003; Chadwick Center 2004). Victims of sexual abuse often hold unhelpful beliefs related to the abuse, including:

- A sense of guilt relating to their role in the abuse;
- Anger at parents for not knowing about the abuse;
- Feelings of powerlessness;
- A sense that they are in some way 'damaged goods';
- A fear that people will treat them differently because of the abuse;
- Behavioural problems/'acting out', such as aggressive, risky or age-inappropriate sexual behaviours;
- Attention/concentration issues, separation anxiety, and extreme impulsivity
- Mental health disorders, including severe depression;
- Posttraumatic stress disorder (PTSD) symptoms

(Child Welfare Information Gateway 2012; Klein and Klain 2013)

A growing body of scientific literature indicates that trauma-informed interventions can be successful in treating child traumatic stress (Klein and Klain 2013). Trauma-informed approaches recognise the effects of traumatic experiences and aim to support recovery rather than exacerbate vulnerabilities.

Trauma-informed services adapt to the needs and experiences of the young person, recognising their victimisation and making any changes needed to help them engage with the service (Macy and Johns 2010). Because trauma-informed work often focuses on attachment and trust issues, 'engagement' and the development of a trusting relationship between a worker and young person vitally underpins this approach. Addressing CSE through trauma-informed approaches may therefore involve longer treatment periods than approaches that primarily focus on behaviour, such as CBT or DBT, which we discuss later in this section.

Trauma-informed work is grounded in creating safety and trust, promoting control, building resilience and empowerment, and prioritising self-empathy and self-care (McKenzie-Mohr et al 2012). The aim is to provide young people with a sense of control and hope, and ideally involves all stakeholders working with the child, including parents/carers and families (Klein and Klain 2013). The focus on self-efficacy and resilience, in addition to recovery, can help young people to achieve a level of stability that enables them to move on after direct work ends (see 2.6).

In recent years there has been considerable interest in Bruce Perry's Neurosequential Model® in the USA, a 'neurobiology-informed approach' to clinical work and caregiving which claims that neglect, chaos, attachment disruptions and traumatic stress all impact the

development of the brain in early childhood and lead to difficulties in impulse control, anxiety in relation to intimacy and abandonment etc (see Perry, 2004; Perry, 2009). The theory is that the brain is altered in destructive ways by trauma and neglect but can also be repaired by exposing the child repeatedly to developmentally appropriate experiences. The approach is not a specific therapeutic technique but an approach to assessment that provides a 'map' of the child's current strengths and vulnerabilities in the context of his or her developmental history. A set of enrichment, educational, and therapeutic interventions is then identified to engage each 'brain area' or function with appropriate activities, including such things as massage, yoga, music and movement. The goal is to provide the 'bottom-up regulation' that can allow other relational and cognitive experiences to impact.

There are currently no evaluations of interventions based on this model and it has been criticised in its use of neuro-science. While it is clear that the first three years of life is a period of rapid brain development, what these changes in brain structure imply for changes in brain function and behaviour is asserted rather than evidence-based (Wastell and White, 2012).

In the UK, Adolescent mentalization-based integrative treatment (AMBIT) is a trauma informed approach that takes Mentalization Based Therapy and applies it to the needs of 'chaotic, complex and multiply comorbid youth.' (See Bevington et al, 2012)

Mentalization Based Therapy (MBT) was developed from Peter Fonagy's research with people diagnosed with borderline personality disorder (BPD) and the recognition of their underlying attachment issues (NICE guidelines now recommend MBT as a treatment for BPD). In MBT the therapist adopts an "inquisitive" or curious stance in order to understand how the client interprets the actions of themselves and others. They model and encourage the development of curiosity in the client. This is mentalization. In terms of direct work with young people, it promotes the use and adaption of existing evidence-based treatments for example, CBT based interventions and Eye Movement Desensitization and Reprocessing (EMDR) as well as mentalization.

In AMBIT the idea is that mentalization is not just applied to direct work with the young person but also in relation to their family or carers, colleagues and peers and the wider multi-agency network. It is not a rigid, manualised model. Instead it encourages the development of a 'learning organisation' – where curiosity extends to colleagues, teams and systems - and it encourages adapting the approach and ways of working to fit local cultures and services (Bevington and Fuggle, 2012).

The AMBIT project is based at the Anna Freud Centre and they have trained about 100 teams around the country to take up the approach. There is some early outcomes evaluative evidence that is quite promising (Fuggle et al, 2014). It was the therapeutic

model used by the South Yorkshire Empower and Protect CSE Innovation pilot (Scott et al , 2017a).

THERAPEUTIC INTERVENTIONS

Therapeutic interventions can use various models, methodologies and theoretical underpinnings or a mix of different therapeutic approaches (Robson 2010). NSPCC's LTFI (Example 1), for instance, utilises fifteen specific interventions, including counselling, symbolic play, solution-focused brief therapy and work on awareness and management of feelings, with creative therapies constituting the most commonly used (20 per cent) of all interventions (Carpenter et al 2016).

In addition to trauma-informed work, other common approaches in direct work with CSE-affected young people include strengths based work that draws on resiliency theory (see 2.4) (Edinburgh and Saewyc 2008; Webb and Oram 2015; Zimmerman 2013) and interventions that aim at behaviour modification or change. Work focusing on behaviour often draws from Cognitive Behavioral Theory (CBT) and/or Dialectical Behavioral Therapy (DBT) and typically starts with an initial highly structured period, with intensity gradually reducing as individuals show that they can modify their behaviour (La Valle et al 2016).

Much direct work with sexually exploited young people, however, is not underpinned by a clear, evidence based theoretical framework but uses 'home-grown' models that are delivered by workers who rely on their knowledge and practice experience of 'what works' in engaging and supporting vulnerable young people (La Valle et al 2016). While there is much good direct work with vulnerable young people that has not as yet been evaluated through rigorous research, the literature highlights the importance of using evidence based models that have demonstrated effectiveness in improving outcomes for young people (Webb and Holmes 2015).

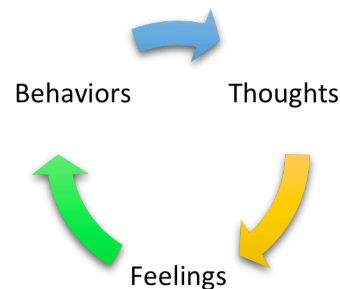
The research evidence may at times seem to reveal contradictory findings; there is evidence to support the effectiveness of relationship-based models that are underpinned by longer periods of engagement and relationship building (see 2.1). At the same time, there is a strong evidence base to demonstrate that shorter term, targeted and goal-oriented interventions, particularly those informed by CBT (see 2.5), are effective in addressing the needs of populations with a range of needs and traumata. Whether an intervention can improve outcomes for young people largely depends on whether the model is suitable to the specific needs of the child.

Cognitive Behavioural Therapy (CBT)

In recent years, there has been a focus on the use of CBT in mental health, youth justice¹⁰

Cognitive Behavioral Therapy (CBT)

CBT is a psychosocial intervention that assumes that the way we think (cognition), feel (emotion) and act (behaviour) is interrelated. It is based on the idea that it is possible to change people's behaviour and emotions through changing the way they think (Wikström and Treiber 2008).



CBT can affect many different areas of cognition and behaviour. They may target emotional characteristics of behaviour, decision-making processes or the application of cognitive activity to behaviour (Coyle 2005).

and related services as 'direct work' with children (Wikström and Treiber 2008; Milkman and Wanberg 2007; Lipsey 2009; Sauter et al 2009).

¹⁰ Applied to the criminal justice setting, CBT is constructed around the notion that cognition affects behavior, and that individuals have the capacity to monitor and adapt their ways of thinking. This can alter how they perceive the settings they encounter and presents possibilities to modify how they respond to those settings, i.e. their (offending) behaviour (Hollin, 1990). Criminologists extend this theory to suggest that offenders may think and feel differently than non-offenders, and this difference in cognition may be causally linked to their offending behaviour (Wikström and Treiber 2008). Although there are many different types of cognitive behavioural interventions, these interventions generally aim to correct deficient, dysfunctional or distorted cognition, which may bolster offending behaviour by teaching new cognitive skills, such as self-monitoring, self-awareness, interpersonal perception, knowledge and consideration of behavioural alternatives, moral reasoning and effective decision-making, which increase awareness of the link between thought processes and maladaptive behaviours, and strengthen an individual's ability to actively alter those processes in a positive way (Landenberger and Lipsey 2005; Meichenbaum 1995; Wilson et al 2005).

CBT is a 'pragmatic', goal-oriented and evidence based intervention

CBT is the best evaluated psychological therapy and, when used in specific, usually time limited, circumstances, has good evidence of efficacy, though its evidence base largely lies in the U.S. It is commonly used to treat anger and behavioural problems, anxiety¹¹ (Cartwright-Hatton et al 2004; James et al 2013), depression¹² (Compton et al 2004; Wantanabe et al 2007; Klein et al 2007), or Post Traumatic Stress Disorder (PTSD) (Taylor and Chemtob 2004). Although many studies have shown CBT to be an effective intervention for many conditions, there are some limitations that we discuss on page 40.

CBT has been adapted for therapeutic work with children and adolescents affected by abuse. Those variations include: Trauma-Focused Cognitive Behavioral Therapy (TF-CBT); Trauma-Focused Cognitive Behavioral Therapy for Childhood Traumatic Grief (TG-CBT) and Cognitive Behavioral Intervention for Trauma in Schools (CBITS) (Kids Mental Health Info Organization).

Is trauma focused CBT (TF-CBT) suitable for direct work with CSE-affected children?

TF-CBT is an evidence-based treatment approach shown to help children, adolescents, and their caregivers overcome trauma-related difficulties (Child Welfare Information Gateway 2012). Apart from being informed by trauma theory, it combines elements from:

- **Cognitive therapy**, which aims to change behaviour by addressing a person's thoughts or perceptions, particularly those thinking patterns that create distorted or unhelpful views;
- **Behavioural therapy**, which focuses on modifying habitual responses (e.g. anger, fear) to identified situations or stimuli;
- **Family therapy**, which examines patterns of interactions among family members to identify and alleviate problems.

TF-CBT is designed to reduce negative emotional and behavioural responses following child sexual abuse, domestic violence, traumatic loss, and other traumatic experiences. Treatment addresses unhelpful beliefs and attributions related to the abuse and provides a supportive environment in which children are encouraged to talk about their traumatic experiences. TF-CBT also helps non-abusive parents to cope effectively with their own emotional distress and develop skills to support their children.

¹¹ CBT is an effective psychological treatment for anxiety disorders in children and gains have been shown to be maintained post treatment.

¹² Evaluations of CBT intervention with children with depression show that most children with depression will show initial remission; 10 per cent within 3 months; a further 40% within first year; and a further 40% next year (Harrington and Dubicka 2001). Up to 70 per cent of children will have a further depressive episode within 5 years (Lewinsohn et al 2000, Fombonne 2001).

TF-CBT is appropriate for children and adolescents, ages 3 to 18, with a history of sexual abuse and/or exposure to other trauma who experience PTSD, depression, anxiety, shame or who demonstrate behavioural problems, including age-inappropriate sexual behaviours. It may not be suitable for children and adolescents with severe behavioural problems that existed prior to the trauma and who may respond better to an approach that focuses on overcoming these problems first. TF-CBT may also not be appropriate for children who are acutely suicidal or who actively abuse substances as the gradual exposure component of TF-CBT (see below) may temporarily worsen symptoms.

What are the typical elements of TF-CBT?

Components of a typical TF-CBT protocol can be summarized by the word 'PRACTICE':

- **P - Psychoeducation and parenting skills**—Discussion and education about child abuse in general and the typical emotional and behavioural reactions to sexual abuse; training for parents in child behaviour management strategies and effective communication;
- **R - Relaxation techniques**—Teaching relaxation methods, such as focused breathing, progressive muscle relaxation, and visual imagery;
- **A - Affective expression and regulation**— Helping the child and parent manage their emotional reactions to reminders of the abuse, improve their ability to identify and express emotions, and participate in self-soothing activities;
- **C - Cognitive coping and processing**— Helping the child and parent understand the connection between thoughts, feelings, and behaviours; exploring and correcting of inaccurate attributions related to everyday events;
- **T - Trauma narrative and processing**— Gradual exposure exercises, including verbal, written, or symbolic recounting of abusive events, and processing of inaccurate and/or unhelpful thoughts about the abuse;
- **I - In vivo exposure**—Gradual exposure to trauma reminders in the young person's environment (for example, basement, darkness, school), so the child learns to control his or her own emotional reactions;
- **C - Conjoint parent/child sessions**—Family work to enhance communication and create opportunities for therapeutic discussion regarding the abuse and for the child to share his/her trauma narrative;
- **E - Enhancing personal safety and future growth**—Education and training on personal safety skills, interpersonal relationships, and healthy sexuality and encouragement in the use of new skills in managing future stressors and trauma reminders.

(Child Welfare Information Gateway 2012)

Is TF-CBT effective?

Particularly in the USA, TF-CBT is being promoted as a 'best practice model' for treating traumatised children (Kar 2011). There is evidence to suggest that TF-CBT is effective and short-term interventions have been found to bring some (long-term) benefits (Cohen and Mannarino 2008).

A review of existing evidence on TF-CBT interventions suggests that CBT is effective for patients with complex trauma histories, including female victims of rape and CSA, and showed that brief CBT treatments improved outcomes on a wider range of symptoms related to complex PTSD with improvements being maintained for at least 9 months (Resick et al 2003). Some evidence from research suggests that TF-CBT is more effective than nondirective or client-centered treatment approaches for children with histories of multiple traumata (e.g. sexual abuse, exposure to domestic violence, physical abuse, as well as other traumata) and for those with high levels of depression prior to treatment (Deblinger et al 2006).¹³ Typical gains include:

- Children experience significantly fewer intrusive thoughts and avoidance behaviours;
- Are able to cope with reminders and associated emotions;
- Show reductions in depression, anxiety, disassociation, behavioural problems, sexualised behaviour, and trauma-related shame;
- Demonstrate improved interpersonal trust and social competence;
- Develop improved personal safety skills;
- Become better prepared to cope with future trauma reminders.

(Cohen et al 2004)

Research also indicates a positive treatment response for parents who reported reductions in depression, emotional distress associated with the young person's trauma, and PTSD symptoms (Cohen et al 2000; Deblinger et al 1996). Parents further reported an enhanced ability to support their children (Deblinger et al 2001; Cohen et al 2004).

¹³ At least 11 empirical studies have evaluated the impact of TF-CBT on child victims of sexual abuse or other trauma (Cohen et al 2004/2005; Cohen and Mannarino 1996/1997; Deblinger et al 2001/2006/1999). A study of CBT interventions for traumatised children following the 1999 earthquake in Athens, for instance, found significant improvements in children at 18-month follow-up that were still present at four-year follow-up (Giannopoulou et al 2006). The effectiveness of TF-CBT with children exposed to domestic violence has also been evaluated (Cohen et al 2011; Weiner et al 2009). The findings demonstrate TF-CBT to be effective in reducing symptoms of PTSD as well as symptoms of depression and behavioural difficulties in children who have experienced sexual abuse and other trauma. In RCTs comparing TF-CBT to other tested models (such as, supportive therapy, nondirective play therapy and child-centered therapy), TF-CBT demonstrated significantly greater gains in fewer clinical sessions. Follow-up studies (up to 2 years following the conclusion of therapy) have shown that these gains were sustained.

Does TF-CBT work in different contexts?

TF-CBT claims to have good transferability and replicability and has been implemented in a range of settings. It has demonstrated effectiveness with children and families of different ethnic and cultural backgrounds and, in the U.S., has been adapted for African-American, Latino, Native American, and hearing-impaired populations (Weiner et al 2009). However, the suggestion that CBT can be adapted to different contexts should be treated with some caution since no meta-analytic study has yet investigated the efficacy of CBT over larger sample sizes on specific subgroups, such as ethnic minorities and low income populations (Hofmann et al 2012).

Current commissioning in the UK frequently favours shorter-length (6-8 weeks) and targeted programs. Depending on the problem, CBT interventions are usually administered in 5 to 20 weekly or fortnightly sessions (Kar 2011; NHS 2016). TF-CBT is usually delivered as a short-term program typically consisting of 12 to 18 sessions of 50 to 90 minutes, depending on treatment needs (Child Welfare Information Gateway 2012). Its cost-effectiveness, in addition to its large evidence base, make CBT-informed approaches a popular choice.

What are the limitations of CBT?

Despite CBT showing some impressive results in a number of treatment areas, there are some issues¹⁴ with regard to sampling¹⁵ and longevity of impact that raise questions with regard to its universal applicability and replicability. Recent comparative studies conducted in everyday clinics in the UK demonstrate lower effect sizes (Stallard 2011).

CBT may also not be suitable or even uncomfortable for some people. For instance, it may not be effective for people with more complex mental health issues or for those with learning difficulties (Kennard 2014). The central focus of CBT is on the client and their capacity to change, which some critics have challenged as being too narrow a focus as it side-lines many important issues, such as family, personal histories, previous traumatic experiences and wider emotional problems. There is limited scope within CBT for personal exploration and examination of emotions, or of looking at troubling issues from a variety of perspectives. Other approaches, including abuse or trauma-informed therapeutic work,

¹⁴ Most trials have been undertaken in the USA or Australia and only a few UK studies have been reported. Sample sizes are often small and many are underpowered (Stallard 2011). The earliest studies were effectiveness studies comparing CBT to waitlist conditions. Follow-up is often lacking and so little is known about the longer term benefits. The age span of children in many studies is large (7-18) - children are generally treated as the same and yet the cognitive, intellectual and reasoning abilities of a 7 year old are very different to those of a 16 year old. Few studies have included younger children and little is known about the effectiveness of CBT on children under 7 years of age.

¹⁵ Many CBT trials have rigid inclusion criteria and the degree to which trial recruits are representative of service referrals is questionable (Stallard 2011). Some PTSD trials excluded participants with developmental delays, no fluency in English, were taking medication, had co-morbidity (e.g. anxiety/depression), were considered too disruptive, or had no long term carer.

psychodynamic/analytic as well as family-based therapeutic interventions may be better suited to address complex and high-level needs resulting from severe trauma.

DIALECTICAL BEHAVIOURAL THERAPY (DBT)

Dialectical Behaviour Therapy (DBT) is promoted as a compassionate and evidence-based model that was originally developed for individuals with borderline personality disorder (BPD) (Linehan Institute). 'Dialectical' refers to the integration of the seemingly opposite strategies of 'acceptance' and 'change'. DBT therapists accept clients as they are while also acknowledging that they need to change in order to reach their goals. DBT teaches skills and strategies that reflect the balance between acceptance and change. For example, the four skills modules include two sets of acceptance-oriented skills (mindfulness and distress tolerance) and two sets of change-oriented skills (emotion regulation and interpersonal effectiveness).

Standard DBT, as developed by Dr. Marsha Linehan, typically consists of the following four components:

- a) DBT skills training group focuses on enhancing clients' capabilities by teaching behavioural skills. The group is run like a class and teaches the skills and assigns homework for clients to practice using the skills in their everyday lives. Groups meet on a weekly basis for approximately 2.5 hours and it takes 24 weeks to get through the full skills curriculum, which is often repeated to create a 1-year program.
- b) DBT individual therapy aims to enhance client motivation and helping clients to apply the skills to specific challenges and events in their lives. In the standard DBT model, individual therapy takes place once a week for as long as the client is in therapy and runs concurrently with skills groups.
- c) DBT phone coaching is focused on providing clients with in-the-moment coaching on how to use skills to effectively cope with difficult situations that arise in their everyday lives. Clients can call their individual therapist between sessions when they need help.
- d) DBT therapist consultation team supports DBT providers in their work with people who often have severe, complex, difficult-to-treat disorders. The consultation team is designed to help therapists stay motivated and competent so they can provide the best treatment possible. Teams typically meet weekly and are composed of individual therapists and group leaders who share responsibility for each client's care.

(Linehan Institute)

Dialectical DBT has been adapted for adolescents (DBT-A) and has been shown to be effective for treating a range of severe and complex mental disorders including PTSD, emotional dysregulation, impulsivity, interpersonal problems, self-harm and suicidal behaviours. However, there is some evidence to suggest that some of the DBT effects may fade over time¹⁶ and that maintenance treatment may therefore be necessary in order to prevent relapse (Van den Bosch et al 2005).

ABUSE FOCUSED THERAPY

'Abuse focused' therapy describes treatment that is directed towards the individual and organised around their experiences (Murray 1999). Rather than being based on one single psychological theory, abuse focused work draws from a wide variety of clinical techniques. It is guided by the principle that abuse is a form of victimisation by the powerful against the powerless and that effects of abuse are a 'normal' adaptation to an 'abnormal' experience (James 1989). Finkelhor and Browne's (1985) framework, which developed a more systematic understanding of the effects of child sexual abuse, identifies four trauma dynamics as forming the core of the psychological injury inflicted by abuse. These are: a) traumatic sexualization, b) betrayal, c) stigmatisation, and d) powerlessness. These dynamics can be used in assessments of victimised young people and help to anticipate problems to which these young people may be vulnerable subsequently.

While the primary focus is to help the child come to terms with the abuse, abuse-focused therapy may include sessions for parents/carers, either in form of parallel or joint sessions. Typical elements of abuse-focused interventions include:

- Encouraging the child to express their feelings relating to the abuse.
- Reviewing erroneous beliefs that might lead to self-blame or other negative attributions about themselves or others.
- Teaching abuse prevention skills.
- Diminishing the sense of stigma and isolation through contact with other victims, e.g. through group therapy. (Finkelhor and Berliner 1995)

FAMILY (SYSTEMS OR SYSTEMIC) THERAPY

Undertaking therapeutic work with young people together with their parents/carers, families or other significant people in their lives can harness the young person's relationships as a resource, which can reduce stress and difficulties for all family members (AFT). Family based therapeutic interventions have been found to be particularly effective for severe and complex disorders requiring extensive treatment, including child (sexual)

¹⁶ Research showed that, while still significant, gains are not as strong at 6-month post-treatment follow-up (Van den Bosch et al 2005).

abuse and neglect, behavioural problems, substance abuse as well as a wide range of mental health issues.

'Family systems therapy' originated in the 1960s and is based on Murray Bowen's family systems theory, which views individuals as inseparable from their network of relationships (Baege 2005; Brown 2008; Winek 2011). While traditional individual (psychoanalytic) therapy frequently focuses on the individual's inner self, family systems therapy addresses the structure and behaviour of the broader relationship system.

Systemic therapy is used in direct work with families, couples, and individuals. Systemic therapists often work with 'genograms', or pictorial representation of a family's history and interpersonal relationships, which can be used for both assessment and treatment (Stratton 2010). Traditionally, family systems therapists may first interview each member of the family in order to create a detailed family history to then use this information to help highlight important information as well as any behavioural or mental health concerns reoccurring across generations. Family systems therapy has been used to treat a variety of mental and behavioural health concerns, such as schizophrenia, alcohol and substance dependency, bipolar, anxiety, personality issues, depression, and eating and food issues, and is considered an effective approach for those concerns that appear to relate to, or manifest within the family of origin (Stratton 2010).

Family systemic therapy is a popular treatment approach despite its limited base of empirical evidence to demonstrate its efficacy. The approach has also been criticised for focusing on the traditional nuclear family even though there are examples, more recently, of family therapy being applied to single parent, blended or other family models (Winek 2011).

ENABLING GROWTH AND MOVING ON

Enabling resilience, growth and recovery is one of the main aims of all direct work and is only possible when a relationship has been established and the young person's safety has increased so that they are in a more stable environment. The foundation that has been built through direct work can help to increasingly diminish reliance upon the service and enable the young person to move into greater independence. The final stage of direct work also raises the issue of 'closure' and needs to consider how to end the relationship that has developed between a worker and a child in a way that is positive.

HOW CAN DIRECT WORK HELP YOUNG PEOPLE TO TRANSITION INTO INDEPENDENCE?

At the end of the journey, direct work should foster the young person's self-reliance and self-efficacy, highlighting what has been achieved, and strengthening their social support system as well as facilitating access to education and training. In addition to building strengths, confidence and resilience, direct work can actively focus on the young person's goals and aspirations.

Adopting a strengths based or 'empowerment' approach (Ungar 2004) is particularly helpful at this final stage of direct work. Supporting the young person's own agency helps them to identify and access protective resources outside of the service. This may include finding positive activities or participation in groups, such as art, music, drama or sport clubs, or opportunities to have their say about a service and become an advocate or mentor. Young people may wish to become active participants in informing policy and practice development on CSE locally or nationally (Cody 2015). In addition to providing diversion, such activities can foster a positive self-identity and help the young person develop new skills and establish a new social network, which can help to prevent revictimisation (see also 2.4).

WHAT NEEDS TO BE IN PLACE WHEN DIRECT WORK ENDS?

Throughout the journey of working with young people, practitioners have to negotiate and maintain appropriate boundaries, which enable them to reduce support towards the end of the work programme (Aldgate and Simmonds 1988). This requires open and sensitive communication with the child that addresses potential anxieties over the transition into independence from the service, which may be compounded by previous experiences of abandonment (Adcock 1988). Ideally, the worker and the young person have jointly reached the decision to terminate service provision because both feel confident that the young person is ready to move on. Involving the young person in developing a 'plan' for the next stage after direct work has ended, such as signposting onto ongoing activities that can fill that gap, can make the next stage easier and close the relationship in a way that feels positive.

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